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ABSTRACT

Analyses of the University of Maryland Counseling Center staff's theoretical orientation were performed, taken both as a whole and individually, and noting the differences among full-time senior staff, part-time staff, and interns. The Therapist Orientation Questionnaire (TOQ) reveals a staff trend toward a "relationship therapy" where the counselor is active, directive, and planful, focusing more on clients' interpersonal behavior than intrapsychic events. Despite a belief in treatment formulation based on psychopathology, their actual orientation tends toward the non-psychoanalytic. Such trends are more applicable to the part-time and associate staff and interns. In contrast, the senior staff appear more psychoanalytically oriented, less active-directive, and less optimistic about the "nature of man." (Author/LJS)

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COUNSELORS' THEORETICAL ORIENTATIONS AT THE COUNSELING CENTER

Ann Peabody and Charles Gelso

Research Report # 2-77

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Summary

Sundland's 1972 form of the Therapist Orientation Questionnaire (TOQ) was administered to all Counseling Division staff members and responses were analyzed by two methods - Sundland's factor analysis (10 factors) and Howard, Orlinsky and Trattner's cluster analysis (five clusters). Medians and ranges for the staff as a whole on each factor and cluster are presented. Additionally, mean item scores and percentiles for each individual staff person are reported. Finally, this report presents mean percentiles separately for senior staff, part-time and associate staff, and interns. Overall, there is a trend for the staff to subscribe to a kind of "relationship therapy," but one in which the counselor is quite actively involved, and does his/her share of talking, guiding, prescribing, etc. Counselors tend to be active, directive, and planful in their counseling, and focus more on clients' interpersonal behavior than intrapsychic events. While the staff subscribes to formulating treatment plans based on knowledge of psychopathology, its orientation tends to be non-psychoanalytic. These general trends were more applicable to part-time and associate staff and interns than to full time staff.

Counselors' Theoretical Orientations at the Counseling Center

Ann Peabody and Charles Gelso

While counselors in the Counseling Division discuss cases with each other a great deal, and in doing so use language that seems to reflect a given theoretical orientation, in the second author's view we know remarkably little about each other in terms of our orientation to counseling/therapy. Indeed, no research has ever been conducted here that would permit comparisons among individual counselors and between relevant subgroups (e.g., senior staff and interns) vis-a-vis theoretical orientation.

We felt the above kinds of comparisons would be both interesting and helpful (probably in an indirect way). The present paper is an informal report that presents such data on theoretical orientations of staff members on Sundland's Therapist Orientation Questionnaire. We sought to provide answers to three questions: (a) What are the theoretical orientations of the Counseling Division staff as a whole? (b) What are the orientations of individual staff members? and (c) Do differences in theoretical orientation exist among full-time senior staff, part-time staff, and interns?

Method

Sample

During Fall semester 1975, Sundland's 1972 version of the therapist Orientation Questionnaire (TOQ) was completed by all senior staff (n = 14) and interns (n = 6). In addition, former interns who had participated in the time-limited therapy study at the CC (n = 5) completed the TOQ. Finally, the three part-time staff members and the two active counseling center associates completed the TOQ.

The TOQ

The TOQ was originally developed by Sundland and Barker in 1961 (Journal of Consulting Psychology, 1962, 26, 201-212), and has gone through three official revisions by Sundland. The 1972 form, the most recent revision, was the one employed in the present study.

The TOQ was designed to measure the theoretical orientations of therapists. The 1972 form contains 104 items. This form contains nearly all of the items from earlier forms, which permits scoring of the new form according to earlier methods as described below. Now, the 1972 form contains 61 items from an earlier factor analysis which uncovered 10 factors. We scored the protocols according to these 10 factors.

In addition to the 10 factors noted above, we scored the TOQ on five clusters (36 items) according to a cluster analysis performed by Howard, Orlinsky and Trattner (J. Counseling Psychology, 1970, 17, 263-270). This second computation was conducted because at least three of the five Howard et al. clusters seemed intuitively interesting, and because two of the clusters, it was felt, might moderate outcomes in the time-limited therapy study being conducted by the second author. (The search for outcome moderators in the TLT study was what stimulated our use of the TOQ to begin with.)

Subjects complete the TOQ by responding to each item (statement) in terms of a 5 point Likert scale as follows: 5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree, 1 = strongly disagree.

Results and Discussion

For the sake of clarity, we shall first present the results of the TOQ scored according to the Howard et al. cluster analysis, and then report them according to the Sundland factor analysis. Under each system of analysis, we shall first look at central tendency for the entire staff, then present data

on individual staff members, and finally report on differences and similarities among senior staff, part-time and associate staff, and interns.

DATA ANALYZED ACCORDING TO THE HOWARD ET AL. CLUSTER ANALYSIS

As indicated, the Howard et al. cluster analysis revealed the existence of five clusters. The items under each cluster are presented in Appendix A. Below are provided brief definitions of the clusters.

I. Psychoanalytic Orientation (13 items): This cluster reflects an approach to therapy in which the therapist maintains a careful, passive, impersonal, theoretically orthodox position with respect to the client, and employs free association and analytic dream interpretation to seek unconscious and infantile determinents of behavior.

II. Impersonal Learning vs. Personal Relationship (8 items): This is a bipolar cluster in which one pole (Impersonal Learning) emphasizes therapy as a verbal, conceptual learning process which is best facilitated by a controlled, nonevaluative, impersonal manner in the therapist. The other pole (Personal Relationship) stresses nonverbal, affective communication in the patient-therapist relationship as the basic therapeutic process which is best facilitated by a frank, spontaneous, personal manner in the therapist.

III. Therapist Role Responsibility (2 items): Cluster three seems undefinable to us. Howard et al. say that the cluster "represents the therapists taking the responsibility for "sensitivity and helpfulness toward the patient." High scores represent the belief that the therapist must be empathically understanding and constantly and deliberately use his/her thorough knowledge of psychopathology and his/her training in techniques to help patients.

IV. Inner Experience (7 items): This cluster assesses the therapist's attention to the client's inner experience as the prime target of therapy, as opposed to the client's manifest social behavior.

V. Therapist Directiveness (5 itmes): The final cluster taps the "tendency to prescribe an actively guiding, instructing, confronting therapeutic approach intended to improve the patient's social adjustment."

Howard et al. also used a single time, not really a statistical cluster, because of its inherent interest. The present authors also scored UM counselors on that item, labeled Recognition of Countertransferance Potential and worded as follows: "My own attitudes toward some of the things my patients say or do stop me from really understanding them."

(a) General Orientation of the Staff. What is our staff like as a whole across the above clusters? Is there a predominant staff orientation? Since the TOQ provides no norms against which to compare the staff, these sorts of questions connot be answered in an entirely satisfactory manner. We may, however, offer some tentative and partial answers by examining medians and ranges of the staff on each cluster. The meaning of these sorts of data must be interpreted with reference to the labels on the 5 point Likert scale. Table 1 gives the median of the mean item score and the range for each Howard et al. cluster. (Remember the scale is 5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree, and 1 = strongly disagree.)

Table 1
Medians and Ranges of CD Staff on the Howard et al. Clusters

Cluster	Median	Range
Psychoanalytic Orientation	2.62	2.15-3.38
Impersonal Learning	2.75	2.13-3.25
Inner Experience	2.57	1.57-3.57
Therapist Role	4.50	3.00-5.00
Directiveness	3.80	3.20-4.60
Countertransference Potential	3.50	2.00-5.00

Interpret these data as you will. Our own impression is that the data suggest the staff as a whole (fulltimers, interns, associates and part-time people) tends to be quite directive and non-psychoanalytic. It appears to attend more to modifying overt social behavior than the client's inner experiencing. At the same time, therapy here tends to be relationship oriented, as opposed to being viewed as a verbal-conceptual learning process in which the therapist is controlled, nonevaluative and impersonal. The high median on Therapist Role indicates that the staff strongly subscribes to the notion that the good therapist must be empathic and, at the same time, constantly and deliberately make use of his/her knowledge of psychopathology and training in

techniques during therapy. It must be kept in mind that the frame of reference for these observations is the 5 point Likert scale, and not some norm group of therapists. How we compare with other groups of therapists and with therapists in general cannot be determined by our data.

(b) Responses of Individual Counselors. What are individual counselors like with respect to therapy orientation as measured by the Howard et al. clusters? How do staff members compare with one another on the clusters? The data in Table 2 provide answers to these questions. The table presents each staff member's mean item score for each cluster as well as each counselor's percentile. Keep in mind that the percentiles are based only on the entire staff, i.e., again, they are not a result of comparison with some external norm.

Table 2

Howard-Orlinski-Trattner Clusters
Mean (X) Scores and Percentiles for Each Individual
(Scale of 1-5)

Name	Psycho-analytic Orienta-tion		Impersonal Learning		Therapist Role		Inner Experience		Therapist Direct-iveness		Counter-trans-ference Potential	
	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile
Beers	2.69	60	3.13	90	4.00	28	2.43	28	3.80	55	3.00	40
Bennett	2.23	10	2.75	47	4.00	28	3.29	92	3.80	55	4.00	70
Birk	2.54	42	3.00	75	5.00	90	3.14	80	4.60	98	5.00	95
Bonz	2.62	52	3.00	75	4.00	28	2.43	28	3.40	20	4.00	70
Boyd	3.38	98	2.63	32	4.50	62	3.29	92	3.20	05	3.00	40
Cohen	2.38	25	2.63	32	3.50	08	2.43	28	4.20	86	4.00	70
Fretz	2.23	10	2.13	03	4.50	62	1.57	02	4.20	87	4.00	70
Gelso	3.23	93	3.13	90	5.00	90	3.14	80	3.40	20	2.00	15
Hill	2.62	52	3.00	75	5.00	90	2.43	28	3.80	55	2.00	15
Hunt	3.23	93	3.13	90	4.50	62	3.14	80	4.00	75	3.00	40
Johnson	2.38	25	2.25	10	4.50	62	2.29	13	3.60	35	5.00	95
Karimi	2.23	10	2.88	60	4.50	62	3.57	98	4.20	86	3.00	40
Kazlo	2.85	73	2.50	18	4.50	62	1.86	05	4.00	75	4.00	70
Leonard	2.31	18	2.63	32	4.50	62	2.43	28	3.20	05	4.00	70
Medvene	3.15	88	2.50	18	4.50	62	2.71	58	3.40	20	4.00	70
McKenzie	2.54	42	2.63	32	4.00	28	2.29	13	3.80	55	3.00	40
McMullan	3.00	82	3.13	90	5.00	90	2.57	48	3.40	20	2.00	15
Mills	2.15	02	2.75	47	3.00	02	3.00	68	3.60	35	4.00	70
Pats	2.46	73	3.25	60	4.50	90	2.57	68	3.60	20	4.00	70
Pavey	2.85	33	2.88	98	5.00	62	3.00	48	3.40	35	4.00	70
Pumroy	2.54	42	2.75	47	4.00	28	2.14	08	3.80	55	2.00	15
Ray	2.77	67	2.50	18	4.00	28	2.86	61	3.80	55	2.00	15
Sigall	2.23	10	2.13	03	3.50	08	2.57	48	4.40	95	4.00	70
Silverman	2.69	60	2.88	60	4.50	62	2.43	28	4.20	87	2.00	15
Stroad	3.08	85	3.00	75	4.50	62	3.00	68	3.80	55	5.00	95
Tanney	2.77	67	2.88	60	4.00	28	2.57	48	3.20	05	2.00	15
Wasserman	2.92	78	2.63	32	4.00	28	3.14	80	3.80	55	3.00	40
Watts	2.62	52	2.25	10	5.00	90	3.29	92	3.80	55	2.00	15
Westbrook	2.46	33	3.00	75	4.00	28	2.43	28	4.00	75	2.00	15
Wine	2.38	25	2.75	47	3.50	08	2.57	48	3.40	20	4.00	70

We feel there is little that can be added by our making observations about these data. Suffice it to say that, in my view (CJG), the data largely confirm in an organized fashion what I had sensed that counselors on the staff were about re theoretical orientation. However, the reader, of course, must make what he/she will of these data.

(c) Intergroup Comparisons. Do relevant differences exist among the senior staff, part-time and associate staff, and interns with respect to theoretical orientation? Table 3 attempts to answer this question by presenting the mean percentiles of each subgroup on each cluster. We did not conduct any tests of statistical significance here. Considering the sample size (especially since the senior staff sample actually is the population) and individual variability, however, it appears safe to view a between - group difference of 25 percentile points or more as "significant."

Table 3 reveals that the fulltime senior staff, in comparison to the part-time and associate staff tends to be more psychoanalytically oriented, and it places a greater emphasis on the client's inner experience, rather than manifest social behavior, as the prime target of therapy. Conversely, the part-time and associate staff tends, to a greater degree than senior staff, to advocate an actively guiding, confronting and instructing therapeutic approach aimed at improving clients' social adjustment.

Interns differ from senior staff in ways similar to those noted above, but to a lesser degree. Additionally, interns differ from both senior and part-time/associate staff in two salient ways that may be indicative of interns training/experience level. Interns gave higher ratings to the one item tapping recognition of countertransference potential. While the difference may reflect a greater self-awareness on the part of interns than the other two groups, the authors are inclined to interpret the difference as indicating, simply, that

interns are less sure of themselves in therapy and are more prone to worry about how their own attitudes inhibit their understanding of clients. The second cluster in which interns differed from the two other groups was "Therapist Role Responsibility." Now, relative to the anchors on our 5 point scale, all groups were high on this cluster (senior and part-time/associate staff = 4.5, interns = 4.1), so the difference may not be practically meaningful. Suffice it to say that interns, to a lesser extent than the other subgroups, subscribed to the beliefs that "the therapist must constantly and deliberately use his/her thorough knowledge of psychopathology and training in techniques to help patients" and "the therapist must be empathically understanding."

Table 3
Mean Percentiles of the Three CC Subgroups on the Howard et al. Clusters

Subgroup	Psychoanalytic Orientation		Impersonal Learning		Therapists Role		Inner Experience		Direct-iveness		Countertrans-ference Potential	
	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile
Senior Staff (N=14)	2.77	62	2.79	47	4.39	62	2.78	58	3.61	35	3.21	40
Part-time & Associate Staff (n=5)	2.42	25	2.65	32	4.3	62	2.26	13	3.96	75	3.2	40
Interns (n=11)	2.61	52	2.76	47	4.18	28	2.77	58	3.85	55	3.45	70

DATA ANALYZED ACCORDING TO THE SUNDLAND FACTOR ANALYSIS

Sundland's more recent, and probably more generalizable, factor analysis revealed the existence of 10 factors. Each factor along with the items subsumed under it is presented in Appendix B for your inspection. Below we provide the labels and brief definitions of the factors. We shall then present the same kind of staff analysis as we did for the Howard et al. cluster analysis.

I. Social Criteria for Success and Deliberate Directiveness (5 items): Taps the therapist's acceptance of the desirability of adjustment toward the goals of society and the therapist's directing his/her patients toward those goals.

II. Affective Gains (5 items): Focuses on therapist's belief that the most important element of therapeutic gain is a learning process that is affective, nonverbal and nonconceptual.

III. Training, Planning and Conceptualizing (9 items): Assesses the therapist's reliance on knowledge of and training in psychopathology and therapeutic techniques and his/her belief in the development of an overall treatment strategy. Low scores reflect the therapist's reliance on his/her own personality and spontaneity.

IV. Verbal Learning and Cognitive Gains (6 items): Taps the extent to which the therapist considers the client's cognitive understanding through a verbal, conceptual process to be the central aspect of therapeutic gain.

V. Psychoanalytic Techniques (9 items): Focuses on the therapist's belief in unconscious motivation and use of classical psychoanalytic techniques.

VI. Active, Involved Therapist (6 items): Reflects the therapist's degree of emotional, personal involvement in therapeutic relationships (high scores), as opposed to an objective, impersonal approach.

VII. Therapist Security (4 items): Probes the degree to which the therapist admits to feelings of insecurity, discomfort, and/or nonunderstanding in some therapeutic relationships.

VIII. Informal Behavior (6 items): Indicates the extent to which the therapist is willing to deviate from his/her formal therapeutic stance with a patient, e.g., offer patient a ride, social visit at patient's home, physical touch.

IX. Inherent Growth (4 items): Focuses on the philosophical belief by the therapist in an innate tendency within people which moves them toward physical and mental health.

X. Interruptive Activity (7 items): Ascertains the therapist's approval of interrupting the client and of being, in general, an active, talkative therapist.

(a) General Orientation of the Staff. The problem of norms discussed in the presentation of general staff data on the Howard et al. cluster applies, of course, to this section as well. Table 4 presents staff medians and ranges for each of Sundland's factors.

Table 4
Medians and Ranges of CD STaff on Sundland's 10 Factors

Factor		Median	Range
I.	Social Criteria & Deliberate Directiveness	3.40	2.00 - 4.20
II.	Affective Gains	3.00	1.60 - 4.00
III.	Training, Planning & Conceptualizing	3.44	2.67 - 4.33
IV.	Verbal Learning & Cognitive Gains	3.00	2.17 - 4.33
V.	Psychoanalytic Techniques	2.67	2.22 - 4.44
VI.	Active, Involved Therapist	3.59	2.83 - 4.50
VII.	Therapist Security	3.00	1.75 - 4.25
VIII.	Informal Behavior	3.10	2.30 - 4.30
IX.	Inherent Growth	3.50	2.00 - 4.75
X.	Interruptive Activity	3.43	2.14 - 4.29

As with the general staff trends for the Howard et al. clusters, the data in Table 4 lend themselves to varied interpretations. In our view, however, there is much consistency between the two analyses (Howard et al. cluster and Sundland's factors). The present analysis supports the earlier one in that it depicts the staff as leaning toward being active, directive, and non-psychoanalytic. We, as a group, tend to be at once relationship oriented in our beliefs about therapy and oriented toward planning strategies based on our knowledge of psychopathology and therapeutic techniques. Additionally, a tendency exists philosophically toward viewing clients as possessing inherent growth tendencies that therapy serves to release. Finally, we get the impression from these data that the staff tends to focus on social and interpersonal goals in therapy rather than intrapsychic ones.

One thing that shows up to a greater extent in this analysis than in the Howard et al. one is the marked intrastaff variability within factors. This variability is exemplified by the wide ranges in Table 4 as regards mean item scores per factor. The variability is shown even more clearly by the within-factor, between-staff mean item scores in Table 5 below.

(b) Responses of Individual Counselors. Mean item scores and percentiles for the staff are presented in Table 5. Again, the data are presented for your inspection and interpretation in light of your perceptions of colleagues and your own self-perceptions regarding the dimensions analyzed.

Table 5
Sundland Factors — Mean (X) Scores and Percentiles for Each Individual
(Scale of 1-5)

	Social Goals and Directiveness		Affective Gains		Training Planning & Conceptualization		Verbal Learning & Cognitive Gains		Psychoanalytic Techniques		Active Involved Therapist		Therapist Security		Informal Behavior		Inherent Growth	
Name	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile
Beers	4.20	97	2.40	27	3.56	58	3.17	70	2.56	32	3.17	25	2.50	20	2.80	35	4.00	72
Bennett	3.40	53	3.20	53	3.89	83	3.00	48	2.33	18	3.17	25	3.50	77	3.50	83	4.00	72
Birk	3.40	53	3.80	88	4.33	98	4.33	98	3.33	82	3.67	55	3.00	55	3.00	45	3.50	43
Bonz	3.60	73	2.40	27	3.78	72	2.50	12	2.44	25	3.83	65	3.50	77	2.80	35	3.00	25
Boyd	3.60	73	4.00	98	3.89	83	3.00	48	3.89	95	3.67	55	3.75	90	2.50	10	2.50	12
Cohen	3.60	73	3.40	63	2.67	03	3.33	80	2.22	08	3.50	43	2.75	35	3.50	83	3.00	25
Fretz	3.80	88	1.60	02	3.33	30	2.83	25	2.89	62	4.50	98	1.75	02	4.00	92	3.50	43
Gelso	2.60	18	3.20	53	3.22	16	3.00	48	3.33	82	3.50	43	2.75	35	2.50	10	3.50	43
Hill	3.00	27	3.80	88	4.00	92	3.17	70	2.67	47	3.33	35	4.00	95	4.30	98	4.50	85
Hunt	3.20	39	3.80	88	3.89	83	4.00	95	4.44	98	4.17	83	2.50	20	3.00	45	4.50	85
Johnson	3.20	39	3.60	75	3.44	48	2.17	02	2.67	47	4.00	75	2.25	10	4.30	98	4.75	95
Karimi	3.60	73	3.80	88	3.44	48	3.67	87	2.00	02	4.00	75	2.75	35	2.70	23	4.00	72
Kazlo	3.20	39	2.40	27	3.33	30	3.17	70	2.78	58	3.50	43	3.00	55	3.00	45	4.75	95
Leonard	2.00	02	3.40	63	3.11	12	3.00	48	3.11	70	4.33	92	2.00	05	3.30	68	3.75	58
Medvene	2.20	07	2.40	27	3.67	63	2.50	12	3.22	75	4.00	75	2.50	20	3.30	68	2.50	12
McKenzie	3.60	73	2.80	47	3.33	30	2.83	25	2.22	08	3.00	18	3.00	55	2.70	23	2.25	05
McMullan	4.20	97	2.00	05	4.11	95	3.00	48	3.33	82	2.83	08	3.50	77	3.20	55	4.00	72
Mills	2.20	07	2.60	42	2.67	03	3.00	48	2.67	47	4.17	83	2.50	20	2.50	10	3.50	43
Pavey	2.60	18	3.80	88	3.33	30	2.33	05	2.67	47	2.83	08	3.00	55	2.30	02	2.00	02
Pats	4.00	92	3.60	75	3.44	48	2.67	87	2.56	32	3.00	18	3.50	77	3.30	68	3.50	43
Pumroy	3.20	39	2.20	10	3.44	48	3.00	48	2.33	18	3.17	25	4.25	98	3.50	83	3.00	25
Ray	3.40	53	2.20	10	3.33	30	3.00	48	2.56	32	3.00	18	3.50	77	2.80	35	3.75	58
Sigall	3.60	73	3.40	63	3.33	30	2.83	25	3.00	65	4.33	92	2.75	35	3.50	83	4.75	95
Silverman	3.40	53	3.60	75	3.89	83	3.00	48	2.22	08	2.83	08	3.00	55	2.70	23	3.25	32
Stroad	3.20	39	2.40	27	3.67	63	3.83	92	3.11	70	3.50	43	2.25	10	3.30	68	4.50	85
Tanney	2.40	12	2.80	47	3.44	48	2.83	25	3.44	90	3.83	65	3.50	77	3.20	55	2.75	18
Wasserman	3.00	27	3.40	63	3.00	08	3.33	80	3.44	90	3.67	55	2.75	35	3.20	55	4.00	72
Watts	2.60	18	2.40	27	3.78	72	2.83	25	2.33	18	4.33	92	3.00	55	3.30	68	2.50	12
Westbrook	3.60	73	2.40	27	3.78	72	3.17	70	2.67	47	3.83	65	3.75	90	2.50	10	3.75	58
Wine	3.60	73	2.40	27	3.22	17	2.50	12	2.67	47	2.66	02	3.00	55	2.70	23	3.50	43

(c) Intergroup Comparisons. Mean percentiles for senior staff, part-ime/associate staff, and interns are presented in Table 6. Between group ignificance tests were not computed. We shall again view a difference of 5 %ile points as "significant."

Again, we find clear similarities of this analysis and the one according o the Howard et al. system. In comparison to the part-time/associate staff, he senior staff tends to be appreciably more psychoanalytically oriented, and ess directive. Senior staff is also less oriented toward social goals in heir therapy (more intrapsychically oriented), and less willing to depart from heir formal therapeutic stance with clients, e.g., less willing to have extra-herapy contacts, engage in physical contact, etc. Finally, the senior staff nds to possess a less optimistic view of clients philosophically (lower score n "Inherent Growth" factor).

There are not as many differences between senior staff and interns, al-hough the differences that do exist are in the same direction as those above. he senior staff, in comparison to interns, tends to be more psychoanalytically riented and less directive. Therapy goals of the senior staff are less riented toward clients' social behavior; and, finally, interns subscribe to greater extent to the belief that people have an inherent growth force that herapy serves to release.

Table 6
Means and Percentiles of the Three CC Subgroups on the Sundland Factors

	Social Goals and Directiveness		Affective Gains		Training Planning & Conceptualization		Verbal Learning & Cognitive Gains		Psychoanalytic Techniques		Active Involved Therapist		Therapist Security		Informal Behavior		Inherent Growth	
Factors	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile	X	%ile
Senior Staff	3.01	27	3.06	52	3.54	58	3.01	48	3.11	70	3.63	55	2.96	55	2.94	45	3.36	32
Part-time and Associates	3.52	73	2.92	52	3.51	58	3.10	70	2.69	47	3.67	55	3.25	55	3.72	83	3.85	58
Interns	3.40	53	2.89	52	3.48	48	3.12	70	2.55	32	3.47	43	2.91	55	3.05	45	3.68	58

CONCLUDING OBSERVATIONS

An analysis of the CD staff's theoretical orientation is seriously hindered by the absence of norms for the TOQ, or similar instruments. Thus, the only frame of reference for such an analysis is the actual 5 point Likert scale used to rate each TOQ item. That is, we may examine staff means only in terms of their location on the rating scale. (As indicated the scale is 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). In addition, a general analysis must not ignore the fact that there is great variability on this staff regarding theoretical (and philosophical) orientation. This variability was highlighted when we scored the TOQ according to Sundland's 10 factors (a more reliable procedure than the Howard et al. cluster analysis). Witness, for example, the range of staff persons' mean item scores on the following factors: "Social Criteria and Deliberate Directiveness" (2.00 - 4.20), "Affective Gains" (1.60 - 4.00), "Inherent Growth" (2.00 - 4.75). Finally, an analysis of the "staff as a whole" must be mindful of the fact that there are at least three subgroups within the staff (interns, senior staff, part-time and associate staff) that differ from one another in terms of theoretical orientation.

With these limitations in mind, it still does seem possible to make some generalizations about the CD staff. The statements below are based on both the Howard et al. and Sundland method of analyzing TOQ responses. In general, it does appear that CD counselors tend to be active, directive, and planful in their therapy. There is a greater emphasis on manifest social/interpersonal behavior of the client than on intrapsychic events. While the staff subscribes to the idea of formulating treatment plans based on knowledge of psychopathology, its orientation in thinking about and treating cases tends not to be psychoanalytic. Overall, the staff appears to subscribe to a kind of "relationship

therapy," but one in which the therapist is quite actively involved, and does his/her share of talking, guiding, prescribing, and the like. Finally, there does appear to exist a tendency toward viewing clients humanistically, in the philosophical sense, i.e., the staff is inclined to believe in the existence of innate growth tendency in people.

When we look at the orientation of senior staff alone or in comparison to interns and part-time and associate staff, a somewhat different picture emerges. That is, while the above generalizations tend to hold up, they are often less pronounced. For example, while none of the three subgroups tend to be heavily psychoanalytic in its orientation, in the Sundland scale labeled "Psychoanalytic Techniques" the senior staff tends to be appreciably higher than the remaining two subgroups (X's = 3.11 vs. 2.67 and 2.56 for the senior staff, interns, and part-time/associate staff respectively). A second example appears on Sundland's factor entitled "Social Criteria and Deliberate Directiveness." The staff median on that scale is 3.40, suggesting an orientation toward guidance and directiveness with clients, where the focus is an outward social behavior. Yet the senior staff mean on this scale is only 3.00, while the interns and part-time and associate staff are 3.40 and 3.60, respectively. Overall, the impression is that the senior staff is more psychoanalytically oriented, less active-directive, and less optimistic about the "nature of man."

We have focused above on general staff patterns and inter-group differences. In our view, however, the most interesting and useful aspect of this study is the data on individual counselors (Tables 2 and 5). While the second author proposes that these data are largely confirmatory of his observations of colleagues (especially when the TOQ was scored according to Sundland's factor analysis), both the Howard et al. and Sundland analyses provide useful frameworks within which to analyze therapist orientation.

We might conclude by mentioning research with the TOQ that is either in progress or being planned. The TOQ was initially given at UM as part of our time-limited therapy study. We are interested in assessing if certain aspects of therapist orientation differentially moderate outcomes in therapy that is time limited vs. not time limited. Second, the present authors are now beginning a study that compares therapist orientation across agencies in the Washington area. We are especially interested in differences and similarities among counseling centers. Finally, we plan to examine changes in the orientation of interns by post-testing them at the end of their internship at the CC.

APPENDIX A

WARD-ORLINSKI-TRATTNER CLUSTERS AND ITEM (Negatively loaded items are preceded by a minus sign.)

Cluster I: Psychoanalytic Orientation

1. A therapist should never interrupt a patient while he is talking.
- 2. People can be understood without recourse to the concept "unconscious determinants of behavior."
3. It is preferable for the therapist to feel impersonal in the therapy relationship.
4. With most patients I do anlytic dream interpretation.
5. I instruct most patients to free associate.
- 6. Inherent in human beings is a natural propensity toward health, physical, mental, and emotional.
7. For a patient to improve his current way of life, he must come to understand his early childhood relationships.
- 8. It is sometimes all right to take a walk with a patient during the therapy hour.
- 9. A treatment plan is not important for successful therapy.
10. There is not an innate tendency in human beings toward emotional health.
11. An effective therapist adheres closely to one major school of thought in conducting his therapy sessions.
12. A therapist should realize that his efforts may prove harmful to patients
13. Good therapists do a lot of talking during the therapeutic hour.

Cluster II: Impersonal Learning versus Personal Relationship

1. A successful adjustment to the social environment is not an important goal of therapy.
2. It is unwise for a therapist's remarks and reactions to a patient to be unplanned, spontaneous, not thought-through.
3. Deliberately expressing approval of desirable patient behavior is not a good therapeutic policy.
4. Patients get better more because their therapists are the kinds of persons they are, than because of their therapist's professional training.
5. The crucial learning process in therapy is a verbal and conceptual process.
6. It is important for the therapist to feel a deep personal and emotional involvement with his patients.
7. In effective therapy, the patient learns mostly through the affective and unverbalized relationship between himself and the therapist.
- 8. A good therapist occasionally makes a patient angry.

Cluster III: Therapist's Role Responsibility

1. A therapist should have empathic understanding of his patients.
2. A good therapist constantly and deliberately uses his thorough knowledge of psychopathology and his training in psychotherapeutic techniques.

Cluster IV: Patient's Inner Experience

- 1. Primary emphasis should be placed on the patient's manifest behavior.
- 2. The patient's coming to experience his feelings more fully is not the most important therapeutic result.
  3. The most beneficial outcome of therapy is for the patient to know the reasons for his behavior.
  4. The social class of a patient should not affect the psychotherapy he receives.
  5. The most beneficial outcome of therapy is the patient's becoming more open to his feelings.
- 6. A good therapist treats the patient as an equal.
- 7. It is quite acceptable to interrupt a patient while he is talking.

Cluster V: Therapist Directiveness

- 1. A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him.
  2. The patient should be directly confronted with evidence of his irrational thoughts and behavior.
  3. It is important for a patient to be helped to make a social adjustment.
  4. The patient should be given useful information to help him achieve his life goals.
  5. A good therapist must guide the patient towards taking responsibility for his own behavior and life situation.

Cluster VI: Recognition of Countertransference Potential

  1. My own attitudes toward some of the things my patients say or do stop me from really understanding them.

APPENDIX B

SUNDLAND FACTORS (Negatively loaded items are preceded by a minus sign.)

Factor I: Social Criteria for Success and Deliberate Directiveness

1. A mature, mentally healthy person will necessarily move in the direction of society's goals.
2. It is important for a patient to be helped to make a social adjustment.
- 3. A successful adjustment to the social environment is not an important goal of therapy.
- 4. Deliberately expressing approval of desirable patient behavior is not a good therapeutic policy.
- 5. Having the patient move in the direction of the goals of society is not an important therapeutic aim.

Factor 2: Affective Gains

- 1. The patient's coming to experience his feeling more fully is not the most important therapeutic aim.
- 2. The patient's coming to accept and experience his feelings is not the primary gain he derives from therapy.
3. The most beneficial outcome of therapy is the patient's becoming more open to his feelings.
4. The most important results of therapy are the new feelings and emotions that the patient comes to experience.
- 5. An affective change in the patient is not the major gain from therapy.

Factor 3: Training, Planning and Conceptualizing

1. No matter how emotionally mature and sensitive a person is, he cannot be a good therapist without training in psychopathology.
2. Effective therapists almost always know what they are doing, and why, and where they are heading.
3. It is unwise for a therapist's remarks and reactions to a patient to be unplanned, spontaneous, not thought-through.
4. It is very important for a therapist to conceptualize, think through, how a patient is relating to him.
5. A good therapist constantly and deliberately uses his thorough knowledge of psychopathology and his training in psychotherapeutic techniques.
- 6. A treatment plan is not important for successful therapy.
- 7. Patients get better more because their therapists are the kinds of persons they are, than because of their therapist's professional training.
- 8. The therapist's personality is more important to the outcome of therapy than his professional training.
- 9. The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling that it is right.

Factor 4: Verbal Learning and Cognitive Gains

1. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist.
2. The most beneficial outcome of therapy is for the patient to know the reasons for his behavior.
3. The crucial learning process in therapy is a verbal and conceptual process.
4. The most important results of therapy are the new idea and new ways of thinking about himself that the patient achieves.
- 5. Understanding why one does things is <u>not</u> the major factor in correcting one's behavior.
- 6. In effective therapy, the patient learns mostly through the affective and unverbalized relationship between himself and the therapist.

Factor 5: Childhood Experiences and Psychoanalytic Techniques

1. With most patients I do analytic dream interpretation.
2. With most patients I instruct them to free associate.
3. For a patient to improve his current way of life, he must come to understand his early childhood relationships.
4. It is important to analyze the transference reactions of the patient.
5. To make sense of a patient's behavior, one must assume motives of which he is unaware.
- 6. It is <u>unnecessary</u> for a patient to learn how early childhood experiences have left their mark on him.
- 7. For a patient to improve his current way of life, he does <u>not</u> necessarily have to come to understand his early childhood relationships.
- 8. People can be understood without recourse to the concept "unconscious determinants of behavior."
- 9. It is possible to make sense of a patient's behavior without assuming motives of which he is unaware.

Factor 6: Active and Involved Therapist

- 1. It is preferable for the therapist to feel impersonal in the therapy relationship.
- 2. Whatever the intensity or nature of the patient's emotional expression, the therapist is most effective when he feels detached, objective, and impersonal.
- 3. The therapist should not act as though he were personally or emotionally involved with the patient.
4. A good therapist expresses to his patients a sense of personal involvement and concern.
5. A good therapist acts personally and emotionally involved and concerned with his patient.
6. It is important for the therapist to feel a deep personal and emotional involvement with his patient.

Factor 7: Therapist's Security

1. A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him.
2. I am very secure and comfortable in my relationships with my patients.
- 3. My own attitudes toward some of the things my patients say or do, stop me from really understanding them.
- 4. At times, I feel contempt for a patient.

Factor 8: Informal Behavior

- 1. It is never all right to offer the patient a ride, or ask him for one.
2. It is sometimes all right to visit a patient socially in his home.
- 3. It is never all right for a therapist to have physical contact with patients (except perhaps for occasional handshakes).
4. It is sometimes all right for a patient and a therapist to embrace.
- 5. It is never all right to accept a friend or relative for psychotherapy.
6. It is sometimes all right to take a walk with a patient during the therapy hour.

Factor 9: Inherent Growth

- 1. People do <u>not</u> have any inherent "drive toward health."
- 2. There is <u>not</u> an innate tendency in human beings toward emotional health.
3. Inherent in human beings is a natural propensity toward health, physical, mental, and emotional.
4. In all human beings there is a sort of "life force," a striving for perfection.

Factor 10: Interruptive Activity

- 1. I would <u>not</u> interrupt a patient during a therapy session as I might if we were having merely a social conversation.
- 2. A therapist should never interrupt a patient while he is talking.
- 3. I am a fairly passive, silent therapist, compared to most therapists.
4. It is quite acceptable to interrupt a patient while he is talking.
5. I interrupt a patient while he is talking.
6. I am a fairly active, talkative therapist, compared to most therapists.
7. Good therapists do a lot of talking during the therapeutic hour.